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MEDICAID GROWTH

SUMMARY

The nation is facing a crisis in Medicaid growth and expenditures. A weak economy, slow or reduced revenue growth for the states and a depletion of rainy day funds have expedited the process of Medicaid reform at all government levels. This bulletin opens the door to a very basic understanding of Medicaid and its growth both nationally and in New Mexico.

WHAT IS MEDICAID?

Medicaid is a jointly funded federal-state health insurance program providing health care for individuals and families with low incomes and limited resources (Centers for Medicare and Medicaid Services (CMS) at: www.cms.hhs.gov). Nationally, Medicaid is projected to cover over 47 million low-income people in 2002, including children, some elderly, blind and disabled persons and people who are eligible to receive federally assisted income maintenance payments (Smith, September 2002). Some Medicaid recipients include the unemployed, working poor and "medically needy", those who have huge medical bills, but otherwise would not qualify for coverage. Currently, New Mexico does not have a "medically needy" category of eligibility.

"Categorically needy" describes groups of people who qualify for the basic mandatory package of Medicaid benefits. States are required to cover some "categorically needy" groups such as pregnant women and children up to 133 percent of the federal poverty level. *"Spending down"* is a process during which medical expenses incurred for a specific period are deducted from an individual's income, thereby making it possible for that person to qualify for Medicaid.

Medicaid coverage generally includes physician services, hospital and nursing facility services, eye care, dental care, prescription drugs, physical therapy, hospice care and rehabilitative services. Within a federal framework of mandated minimal coverage, every state differs in the type and level of services provided under the Medicaid program. Some states provide screening, prevention and diagnostic services for adults, as well as chiropractic services and occupational therapy. Medicaid recipients typically do not pay deductibles, premiums,

out-of-pocket fees or co-payments; however, the escalating costs of Medicaid have caused states to consider and to implement various cost-sharing proposals to curb Medicaid growth. Federal law places certain restrictions on the states' authority to require cost-sharing.

IMPACTS OF MEDICAID

- Medicaid provides better access to health care, improving preventive care and overall health for the low-income population, the elderly and the disabled.
- It increases health care for unwed mothers, newborns and poor children, covering preventive and health maintenance services, which in the long run will save money by allowing these people to lead healthier lives.
- Medicaid provides significant support for hospitals and other health care providers, thereby sustaining local health economies.
- Public hospitals that carry a large financial burden providing services to low-income and uninsured patients can benefit from the subsidies provided through Medicaid and its *disproportionate share hospital payments. These payments are from federal dollars awarded to hospitals that provide care for a disproportionate number of indigent and extremely medically needy clients.* Local government indigent funds carried a greater burden for covering these expenses before the federal subsidies were available.

NEW MEXICO QUICK FACTS

Medicaid enrollment in New Mexico has tripled since 1991, providing health care coverage for one of every five people in New Mexico (Human Services Department (HSD), November 2002).

New Mexico Medicaid expenditures increased more than 131 percent between 1995 and 2002, covering a 65 percent increase in enrollment during that period (HSD, 2002).

(cont'd.)

For fiscal year (FY) 2003, projections indicate that federal and state Medicaid expenditures in New Mexico will surpass \$1.95 billion, \$50.8 million more than the FY 2003 general fund

appropriation (HSD, 2003). A \$19.5 million contingency fund appropriation has reduced the general fund shortfall to \$31.4 million.

New Mexico enrollment in July 2002 included 382,200 people, 255,273 of whom were children (HSD, 2002).

Two-thirds of the total enrollees are in the *managed care organization (MCO) called Salud!* and one-third are in a *fee-for-service program*.

Total enrollment is projected to reach 417,058 by June 2003 and 455,803 by June 2004 (HSD, 2003).

In New Mexico nearly every dollar of state funding for Medicaid costs qualifies for at least a \$3 match from the federal government; however, the match for the *State Children's Health Insurance Program (SCHIP)* is \$4 for every \$1 spent by the state. (See Federal Match Rates below)

MEDICAID IS NOT THE SAME AS MEDICARE

Medicare is a federal program of health care coverage for people 65 years of age or older, certain younger people with disabilities and people with end-stage renal disease (permanent kidney failure with dialysis or a transplant).

Medicare is divided into two parts: Part A, which covers inpatient care, hospice and home health; and Part B, which covers physician and outpatient services. Part A is automatically available to those who qualify, while Part B is purchased with a monthly premium. Nursing home care and outpatient prescription drugs are not covered benefits under Medicare, except in very limited situations.

BACKGROUND

Congress adopted amendments to the Social Security Act in 1965 (P.L. 89-97), which created Medicare (Title XVIII) and Medicaid (Title XIX) as the federal health care programs for the elderly and low-income, respectively. Previously, charities and community hospitals provided most emergency health care services to many indigent people, with state and local governments providing a combination of programs to address health care. In 1988, the federal Family Support Act extended Medicaid coverage to more low-income Americans holding jobs, but with no health coverage. Before this act was passed, welfare recipients were at risk of losing coverage if they earned too much to qualify. The change extended benefits to families losing their Aid to Families with Dependent Children benefits, because of higher earnings and expanded coverage for two-parent families whose principal earner had become unemployed. SCHIP (Title XXI), the largest expansion of Medicaid since its inception, was adopted in conjunction with the federal Balanced Budget Act of 1997 and expanded eligibility to children.

Medicaid has a long legislative history, which may be reviewed in *Medicaid: A Primer*, as prepared for the Kaiser Commission on Medicaid and the Uninsured, March 2001 at www.kff.org.

CRISIS IN MEDICAID

Growth, Nationally

As reported by the Kaiser Commission on Medicaid and the Uninsured (September 2002 and January 2003):

- Medicaid is expected to cover 47 million people in 2002, including 24 million children, 11 million adults and more than 13 million elderly and disabled.
- Medicaid spending growth for fiscal year (FY) 2003 is forecast at an average 9 percent for the states, with enrollment growth projected at an average 7.7 percent for FY 2003.
- A little more than **25 percent of the Medicaid enrollees are elderly and disabled**; they tend to use more expensive services and **account for two-thirds of Medicaid spending**.
- **Medicaid enrollment increased 9.8 percent** from December 2000 to December 2001 (Kaiser, October 2002), **Medicaid spending increased by 12.8 percent** in fiscal year 2002, with the states' share increasing 11 percent. States only appropriated an average 4.8 percent increase for FY 2003, resulting in serious deficit issues for them.
- Medicaid is the largest single purchaser of maternity care and pays for one-half of all nursing home care.
- Medicaid is the largest source of federal funds to the states, accounting for 43 percent of all federal grants-in-aid.
- Federal Medicaid matching payments are projected to be \$147 billion for FY 2002.

New Mexico has identified prescription drugs, expansion of enrollment and cost inflation factors as the primary reasons for Medicaid growth.

The Kaiser Commission's *Medicaid Spending Growth: Results from a 2002 Survey* summarizes reasons reported by the states for Medicaid expenditure growth in FY 2002:

- Increased spending on **prescription drugs**, which is driven by:
 - a. increased use of drugs, including new, more expensive drugs;
 - b. price increases for prescription drugs; and
 - c. pharmacy-driven capitation rate increases for MCOs.

Capitation rates refer to payments made to the MCO on a monthly basis at a fixed, contracted amount for each Medicaid beneficiary enrolled in the MCO.

Increased enrollment, cited as one of the greatest sources of Medicaid spending growth in 39 states, has the following dynamics underlying its growth in enrollment and expenditures:

- a. the **economic downturn**, causing more people to qualify for Medicaid;
- b. **expansions in eligibility and outreach** that states have undertaken in recent years;
- c. **administrative simplifications** aimed at increasing enrollment;
- d. **successful outreach**, which has increased participation in SCHIP;
- e. the **increased cost and use of medical care services**; and
- f. **the costs of long-term care**. The last two factors, along with prescription drug costs, are significant factors driving the increase in private sector health insurance.

Spending Pressures (Sandi, 2002)

- C Nationally, general tax revenues were projected to drop 3.8 percent for 2002, while Medicaid was projected to grow 11 percent.
- C Rainy day and reserve funds are already being drained.
- C Net borrowing by state and local governments is at record levels.
- C Spending pressure in budgets is increasing, led by Medicaid costs.

The Medicaid Dilemma (Smith, May 2002)

- C The Medicaid need is going up just when the states' ability to pay for it is going down.
- C States must cut total Medicaid spending \$2 to \$4 to save \$1 in state funds.
- C Every Medicaid cut affects individuals who need health care services and local health care providers.
- C Medicaid spending cuts are usually needed immediately, but it takes time to achieve savings, and state fiscal capacity is too limited to finance Medicaid expenditure growth.
- C Choices are limited by federal rules, but all the important decisions about Medicaid are made by the states.

Cost Containment Actions by the States (Smith, May/September 2002)

National options considered for FY 2002 included:

- C cuts and restrictions in eligibility, benefits and payments;
- C cost containment actions in pharmacy, hospital, long-term care and managed care; and
- C the addition of supplemental funding.

The cost containment actions most frequently used by the states include:

- C prescription drug cost controls;
- C reductions or freezes in provider payment rates;
- C benefit reductions;
- C reductions and restrictions in Medicaid eligibility; and
- C increased beneficiary co-payments for services other than prescription drugs (e.g., cost-sharing).

States are implementing these actions to slow growth in Medicaid, while studying changes to Medicaid programs that will result in long-term impacts. New Mexico officials will continue to review methods of addressing funding dilemmas for health care.

FEDERAL MATCH RATES

In any Medicaid funding mechanism, states find it critical to capture every eligible dollar of Medicaid costs to leverage for federal reimbursement at the multiple dollar rate. This involves identifying services that are reimbursable through Medicaid, but are currently funded with state dollars. Certain basic services must be offered to the categorically needy population in any state program in order to receive federal match dollars.

The federal medical assistance percentages (FMAP), or reimbursement rates, for Medicaid and SCHIP are determined annually for each state by a formula that compares the state's average per capita income level with the national average (CMS, September 2002).

Typically, FMAP cannot be lower than 50 percent or greater than 83 percent, and most administrative costs are matched at 50 percent for all states. Some services are matched at higher rates, including certain family planning costs that have a 90-percent match and services rendered to Native Americans at Indian Health Services or tribal operated facilities, which are reimbursed 100 percent.

The table below reflects FMAP rates:

Medicaid (Title XIX)

FFY2002* Fed: 73.04 percent (NM: 26.96)
 FFY2003 Fed: 74.56 percent (NM: 25.44)
 FFY2004 Fed: 74.85 percent (NM: 25.15)

SCHIP (Title XXI)

FFY2002 Fed: 81.13 percent (NM: 18.87)
 FFY2003 Fed: 82.19 percent (NM: 17.81)
 FFY2004 Fed: 82.40 percent (NM: 17.60)

*FFY refers to federal fiscal year.

IMPACT OF 2000 CENSUS UNDERCOUNT

A 2001 study by PricewaterhouseCoopers estimated the impact of the projected Census 2000 undercount on the allocation of federal funds. A calculation was made of the amount of lost funding to the states under eight federal grant programs, including Medicaid. "Of the eight programs analyzed, Medicaid accounts for 92 percent of the federal funds that would be shifted as a result of the Census 2000 undercount." New Mexico has the fourth-highest percentage undercount of the states. During calendar year 2003, New Mexico is projected to lose \$208 per uncounted individual, or nearly \$7.5 million for these programs. The long-term impact for 2002-2012 is projected at \$3,055 per uncounted person, or \$110 million.

ADMINISTRATION OF MEDICAID

Medicaid is administered at the federal level by the Centers for Medicare and Medicaid Services. The Medicaid program in New Mexico is administered by the Human Services Department (see web site at: www.state.nm.us/hsd and Chapter 27 NMSA 1978 regarding public assistance). The Department of Health manages waivers for some Medicaid programs, and the Children, Youth and Families Department determines medical necessity for some services and eligibility for certain categories of children.

REFERENCE LIST

Centers for Medicare and Medicaid Services at:
<http://cms.hhs.gov/Medicaid>.

Chapter 27 NMSA 1978 and related statutes.

Federal Family Support Act of 1988 (P.L. 100-485).

Federal Omnibus Reconciliation Acts of 1986-1990 and 1993 (P.L. 99-509; 100-203; 101-239; 101-508; 103-66).

Federal Social Security Act of 1965 (P.L. 89-97) at:
www.ssa.gov/OP_Home/ssact/comp-toc.htm.

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Medicaid: A Primer. March 2001. Web site: www.kff.org.

Medicaid Enrollment in 50 States. December 2001 Data Update. October 2002.

Medicaid Spending Growth: Results from a 2002 Survey. Prepared by Vernon K. Smith, Ph.D., Eileen Ellis, Kathy Gifford, Rekha Ramesh and Victoria Wachino. September 2002.

Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003. January 2003.

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Report to the Medicaid Reform Committee by the Medical Assistance Division. November 6, 2002.

Medicaid Program - Revised Projections. January 15, 2003.

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Sandi, Mark M., *The Outlook for State Tax Revenues*, www.economy.com. February 2002.

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This document contains information and excerpts from reports and presentations made to the 2002 interim Medicaid Reform Committee (MRC) as well as additional cited sources. Roxanne Knight condensed them in consultation with Raul Burciaga. The final report of the MRC may be obtained by contacting the Legislative Council Service at (505) 986-4600. This document may be viewed on the Legislative Council Service website. This document does not represent a policy statement of the Legislative Council Service or its staff.

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